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Fourth Report

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EXPERT COMMITTEE ON VENEREAL INFECTIONS AND TREPONEMATOSES

Fourth Session

London, 28 July - 2 August 1952

Members :

Dr. J. M. de Barros, Assistant Professor of Venereology, School of Hygiene and Public Health, University of São Paulo, Brazil

Dr. T. J. Bauer, Chief, Division of Venereal Disease, US Public Health Service, Washington D.C., USA *(Rapporteur)*

Dr. H. T. Chaglassian, Professor of Dermatology and Syphilology, American University, Beirut, Lebanon

Dr. E. I. Grin, Director, Central Dispensary for Skin and Venereal Diseases, Sarajevo, Yugoslavia

Dr. G. L. M. McElligott, Director, Venereal Disease Department, St. Mary's Hospital; Adviser in Venereal Diseases, Ministry of Health, London, United Kingdom of Great Britain and Northern Ireland *(Chairman)*

Dr. R. V. Rajam, Professor of Venereology, Government General Hospital, Madras, India

Dr. M. Soetopo, Professor of Dermato-Syphilology, Director, Venereal Disease Research Institute in Indonesia, Surabaya, Indonesia *(Vice-Chairman)*

Consultants on special agenda items :

Dr. N. Danbolt, Professor of Dermatology and Syphilology, University of Oslo, Norway

Dr. S. Hellerström, Professor of Dermato-Syphilology, University of Stockholm, Sweden

Dr. E. H. Hermans, Director, Rotterdam Port Demonstration Project, Rotterdam, Netherlands

Dr. P. V. Marcussen, Chief, Dermatology Department, Finseninstitutet og Radiumstationen, Copenhagen, Denmark

Secretariat :

Dr. T. Guthe, Chief, Venereal Diseases and Treponematoses Section, WHO *(Secretary)*

Dr. F. W. Reynolds, Venereal Diseases and Treponematoses Section, WHO

Dr. P. Krag, Biological Standardization Section, WHO

Dr. F. Soliman, Regional Adviser on Venereal Diseases, WHO Regional Office for the Eastern Mediterranean

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EXPERT COMMITTEE ON VENEREAL INFECTIONS AND TREPONEMATOSES

Fourth Report [1]

1. INTRODUCTION

The Expert Committee on Venereal Infections and Treponematoses met in London from 28 July to 2 August 1952.

The committee unanimously elected Dr. G. L. M. McElligott as Chairman and Professor M. Soetopo as Vice-Chairman. Dr. T. J. Bauer was elected Rapporteur. Several members of the WHO Expert Advisory Panels on Venereal Infections and Treponematoses, including Serology and Laboratory Aspects, attended some of the meetings.

This was the fourth session of the committee and the first for which the terms of reference formally included the non-venereal treponematoses, in accordance with the decision of the Executive Board at its fifth session.[2] A number of panel members (from 44 countries), including experts on serology and laboratory aspects, had been appointed by WHO to advise on venereal infections and treponematoses. Twenty-five members of this panel who had attended the Tenth International Congress of Dermatology in London during the week preceding the session of the committee held consultations on technical and other matters of interest to WHO.

The comments of the Executive Board on the report of the third session of the committee [3] were noted. Full consideration was given to these comments throughout the meetings. Particular attention was paid to the

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[1] The Executive Board, at its eleventh session, adopted the following resolution:
The Executive Board
1. NOTES the fourth report of the Expert Committee on Venereal Infections and Treponematoses;
2. THANKS the members of the committee for their work;
3. DRAWS the attention of governments to relevant recommendations contained in the report, and
4. AUTHORIZES its publication.
(Resolution EB11.R15, *Off. Rec. World Hlth Org.* **46**, 5)

[2] *Off. Rec. World Hlth Org.* **25**, 11

[3] *World Hlth Org. techn. Rep. Ser.* 1950, **13**

approval by the Board of the public-health outlook previously advocated by the committee, with emphasis on the maintenance of a balance between selective programmes and an overall programme of disease prevention, including the training of personnel for public-health, clinical, and laboratory purposes in regions where limited facilities exist.

Consideration was given to the committee's relationship with its Subcommittee on Serology and Laboratory Aspects, the report on the second session [4] of which had been approved by the members of the third session of the main committee after consultation by mail. The subcommittee's report was subsequently approved by the seventh session of the Executive Board.[5]

The committee noted the resolution of the Executive Board at its seventh session with regard to the International Anti-Venereal-Disease Commission of the Rhine,[6] and that of the Third World Health Assembly [7] on the report of the first session of the Joint ILO/WHO Committee on the Hygiene of Seafarers,[8] as well as the resolution adopted by the ninth session of the Executive Board on the most effective utilization by WHO of short-term consultants.[9]

The extensive preparatory documentation made available to the members of the committee (see Annex 1, page 41) was noted with satisfaction and carefully studied in relation to the agenda, the development and status of the WHO venereal-disease and treponematoses programme, including laboratory aspects, and the present and projected scope of the work.

In its deliberations, the committee placed major emphasis on technical orientation and epidemiological considerations relating to the large-scale programmes now being carried out by certain health administrations with international assistance. The general outlook of WHO in its approach to control programmes against venereal infections and treponematoses in the light of past experiences was considered, but as far as possible the still-valid considerations from previous sessions are not reiterated in the present report.

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[4] *World Hlth Org. techn. Rep. Ser.* 1951, **33**

[5] Resolution EB7.R66, *Off. Rec. World Hlth Org.* **32**, 28

[6] Resolution EB7.R24, *Off. Rec. World Hlth Org.* **32**, 7

[7] Resolution WHA3.31, *Off. Rec. World Hlth Org.* **28**, 26

[8] *World Hlth Org. techn. Rep. Ser.* 1950, **20**

[9] Resolution EB9.R41, *Off. Rec. World Hlth Org.* **40**, 14

2. DEVELOPMENTS AND PERSPECTIVES

2.1 General Outlook

The rationale for an outlook by WHO on treponemal diseases—namely, syphilis, bejel, yaws, and pinta—as a group, was recognized by the third session of the committee in 1949 [10] and subsequently approved by the governing bodies of WHO. There is ample evidence that the diseases caused by treponemes have much in common: the causative agents are morphologically and immunologically related; there are comparable, if not always identical, responses to infection on the part of the human host; the outcome of effective therapy in all syndromes is prompt and favourable; and, finally, penicillin is unique in its applicability as a preventive, abortive, and curative weapon, and there continues to be an absence of penicillin resistance in the treponemes. These are the major elements which have contributed to the delineation of a more rational concept of, and approach to, the control of the treponematoses in individuals as well as in large population-groups. From the public-health viewpoint there are definite practical advantages in this overall view, as opposed to concepts based on the mode of transmission or on variations in resultant clinical syndromes.

Notwithstanding a substantial decline in the incidence of infectious venereal syphilis in Australia, Europe, North America, and limited areas elsewhere, since the second World War, important reservoirs remain in many other parts of the world. Furthermore, non-venereally-transmitted treponemal disease in children has been identified as an important health problem during the last several years. Examples of this are the " endemic syphilis " in Bosnia (Yugoslavia), Madras (India), Bechuanaland (South Africa), and Tahiti (South Pacific); " njovera " in Southern Rhodesia; and " bejel " in the Eastern Mediterranean region. In addition, pinta remains endemic in some areas in Central and South America. These are non-venereal treponematoses, in many ways clinically similar or identical to syphilis, but epidemiologically comparable to yaws. Yaws remains a serious social and economic burden of rural populations in tropical areas where lives a great proportion of the world's total population.

While it is recognized that, over the last few years, encouraging initial results have been obtained in national health programmes with or without WHO assistance, the committee wishes to emphasize the continuing need for the active encouragement of treponematosis-control measures in many

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[10] *World Hlth Org. techn. Rep. Ser.* 1950, **13**, 13

countries where organized programmes have not yet been initiated. Long-range planning is also necessary in areas where active programmes are under way and the reservoir of infection is being brought under control. Reorientation and further emphasis on case-finding by the use of new techniques may thus become desirable. This is now the case in many developed countries with regard to early venereal syphilis. More detailed attention to late manifestations of this and the other treponematoses has also, in some areas, become a desirable public-health objective. Without a flexible, long-term, purposeful programme which can meet the public-health needs as they arise, the progress in the control of treponemal diseases made in recent years might be placed in jeopardy.

With regard to venereal infections of non-treponemal origin—namely, gonorrhoea and non-gonococcal urethritis, chancroid, lymphogranuloma venereum, and granuloma inguinale—the outlook remains essentially the same as that expressed in the committee's report on its third session. The committee wishes to repeat the views previously emphasized that special attention should be given to these diseases by WHO where particular geographical or other considerations pertain. Some further aspects relating to these disease entities are referred to in section 7, page 37, dealing with non-treponemal venereal infections.

Venereal infections, and non-venereal treponematoses and their sequelae, limit employability for work and result in chronic disability which reduces work-efficiency in industry and agriculture at the most productive period of life. On the basis of detailed information received during the last few years as a result of WHO-assisted control programmes in several regions, it is known that the prevalence of yaws in underdeveloped areas may be as high as 25%-30% in large, rural populations. In the current yaws-control programme in Haiti it has been estimated that some 100,000 incapacitated people have been returned to work, thereby increasing the national production by several million dollars a year. Because of the economic consequences attributable to these diseases, health programmes directed against them are considered appropriate fields of activity under the United Nations Expanded Programme of Technical Assistance for the Economic Development of Underdeveloped Countries. The committee noted that this principle had been accepted by WHO and by the Technical Assistance Board (TAB); it also noted the manner in which technical assistance was rendered, as set forth by the TAB and as outlined by the Economic and Social Council at its ninth session.[11] The committee also expressed the hope that co-operation between health administrations, the United Nations International Children's Emergency Fund (UNICEF), and WHO for the

[11] United Nations (1949) *Economic and Social Council. Official Records : fourth year, ninth session. 5 July - 15 August 1949. Supplement No 1. Resolutions*, Geneva, p. 4, resolution 222 (Document E/1553)

benefit of mothers and children would continue beyond the programmes actually being implemented against the treponemal diseases at the present time. In studying the selective public-health programmes embarked upon by WHO in support of national health-administrations which have requested assistance in the initiation, development, and follow-up of treponemal-disease-control programmes, including laboratory aspects, the committee noted the progress made in several countries which are Member States of WHO. An estimated total of five million people have been examined in such programmes over the last three years, and approximately two million people have been treated with penicillin. Data from six of the larger " mass " programmes are summarized in table I.

TABLE I. NUMBER OF PERSONS EXAMINED AND TREATED IN SIX WHO/UNICEF TREPONEMAL-DISEASE-CONTROL PROGRAMMES

Programme	Duration	Number examined	Number treated
Haiti (yaws)	July 1950 - April 1952		944,139
Indonesia (yaws)	May 1950 - July 1952	2,649,913	404,382
Iraq (bejel)	October 1950 - July 1952		14,980
Philippines (yaws)	August 1951 - July 1952	394,281	20,691
Thailand (yaws)	May 1950 - August 1952	1,516,801	205,858
Yugoslavia (endemic syphilis)	January 1949 - December 1951	941,563	91,988

In reviewing these programmes, the committee stressed the role of medical advances as " pacemakers " of social change and noted the preliminary report on the world social situation submitted by the Secretary-General of the United Nations to the United Nations Social Commission at its eighth session, which stated : " In the underdeveloped areas ... release of the resources of the countries from the tangled undergrowth of mass diseases is a prerequisite of development ".[12] Penicillin in mass diseases like syphilis and yaws is, indeed, an important pacemaker of this kind, and its impact on underdeveloped areas should be carefully studied. It is logical that the outlook of WHO should continue to be directed towards the less highly developed areas, where the attack-rates of the non-venereal treponematoses are high in the lower age-groups, where infantile syphilis and syphilis in pregnancy are prevalent, and where active control-work or further teaching, training, and laboratory facilities are required.

The committee reviewed the various elements in the selective public-health programmes of WHO against venereal infections and treponematoses, including demonstration and survey aspects, training and consultant

[12] United Nations (1952) *Preliminary report on the world social situation with special reference to standards of living*, New York, chapter III, p. 32 (document E/CN.5/267/Rev.1)

activities, fellowships, symposia, special literature and exchange of scientific information, grants-in-aid, etc. With regard to these programme elements, the general outlook of WHO and its approach to health administrations remain essentially as outlined in previous reports of the committee. It was also emphasized that joint programmes with other health activities —maternal and child health, malaria, tuberculosis, health education, and others—are desirable whenever initial surveys and exploration of the health problems in an area show technical and administrative advantages. Single-phase or joint activities should, as soon as possible, serve as bridgeheads for wider, multiphasic, public-health activities, since isolated efforts directed towards specific health problems will have difficulty in surviving unless integrated into an overall programme. Control programmes against venereal infections and treponematoses would seem to be suitable bridgeheads for further health work, particularly the large-scale campaigns against treponemal diseases now under way in many areas. In reviewing the experiences of health administrations in such programmes, it was found desirable to consider in some detail the techniques by which treponemal diseases can now be effectively suppressed and perhaps ultimately eliminated as major health problems. One of the aims of WHO should be to assist health administrations in working towards the latter objective.

2.2 The Approach of WHO to Treponemal-Disease Control

It has been stated that " penicillin is not public health ". Supplies alone will not assure success in a selective public-health programme against treponemal diseases. However, with its triple potential of (*a*) preventing infection on exposure, (*b*) aborting the infection in the incubation period, and (*c*) curing the established disease, penicillin is a powerful weapon in organized treponematosis-control work. Present knowledge indicates that mass diagnosis and treatment programmes, when carefully planned and systematically carried out, will result in a significant reduction in the incidence of infectious cases and in the general prevalence of the treponematosis (see table II); and, under favourable circumstances, infectivity can be completely eliminated (see table III and fig. 1).

The techniques of conducting control programmes with repository penicillin and by mass case-finding are still being perfected. In each programme it is essential to establish at least one controlled, local study-area with adequate laboratory facilities where detailed evaluation of various epidemiological methods, response to treatment schedules, etc., can be made. The knowledge acquired in such controlled, local study-areas (" pilot areas ", " primary areas ") will serve as a basis for the broader mass-programme as it develops. The selection and size of such controlled study-areas will depend upon a great many factors, several of which are